CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155614	B. WIN			11/17/2	011
NAME OF D	DOMINED OF CLIDDLIED			STREET .	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			326 CC	OUNTRY CLUB DRIVE		
	I HILLS OF NEW AL				LBANY, IN47150		
(X4) ID		FATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
	•				CROSS-REFERENCED TO THE APPROPRIA	ΓE	
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY)		DATE
PREFIX TAG F0000	This visit was for Complaint IN000 Complaint IN000 Federal/state defi allegations are cirand F514. Survey date: 11/1 Facility number: Provider number AIM number: 10 Survey team: Jer Census bed type: SNF: 9 SNF/NF: 116 Total: 125 Census payor typ Medicare: 9 Medicaid: 94 Other: 22 Total: 125 Sample: 4 These deficiencies	099832. 099832 - Substantiated. iciencies related to the ted at F157, F309, F315 17/11 000321 : 155614 00286130 nnie Bartelt, RN	F0	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	this ion sion of or he state ot in	COMPLETION DATE
LABORATOR	V DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SE	CNATIDI	7	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

890C11

Facility ID:

000321

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/17/2011	
		100014	B. WING	ADDRESS OF STATE STROOPS	11/11/2011
NAME OF F	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE DUNTRY CLUB DRIVE	
	N HILLS OF NEW A		NEW A	ALBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
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1710		completed on November	1716		BATE
	21, 2011 by Bev				
	21, 2011 0, 201	Tualities, Terv			

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155614		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/17/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0157 SS=D	resident; consult wand if known, notif representative or a when there is an a resident which respotential for requir significant change mental, or psychodeterioration in he psychosocial statuconditions or clinical ter treatment significant treatment significant or discontinue an exito adverse consectine form of treatment transfer or discharfacility as specified. The facility must a resident and, if known there is a change in resident as spead change in resident state law or regular paragraph (b)(1) of the facility must resident's legal registeries and on record.	is in either life threatening cal complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the lown, the resident's legal interested family member lange in room or roommate excified in §483.15(e)(2); or ent rights under Federal or actions as specified in of this section. Second and periodically is and phone number of the presentative or interested inter	F0	157	The facility will continue to immediately inform the		12/13/2011	
	timely about a recondition. The data of 4 residents rechange in condition hospitalization in	-			resident/responsible party ar consult with the resident's physician when there is a significant change in the resident's physical status tha may require an alteration in treatment. For Resident B, the facility did notify the MD on 9	ıt e		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID: 8	390C11	Facility I	D: 000321 If continuation sl	heet Pac	ge 3 of 21	

890C11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155614	B. WIN			11/17/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	UNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW A	LBANY			LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	multiple episode	es of vomiting and large			at 10:00 am regarding the distended abdomen and resi	-14	
	bowel movemen	its. The resident's			was sent to the hospital.	aent	
	abdomen was as	sessed as hard and			Resident readmitted to facilit	v at	
	distended at 6:00	a.m., and the assessment			this time with no further prob		
	was not reported	to the physician until			noted.Any resident exhibiting		
	10:00 a.m.	1 5			gastrointestinal symptoms w		
					hard and distended abdome		
	Findings include	<u>.</u>			the potential to be affected. 24-hour shift report has beer		
	1 mamgs merade	··			reviewed to ensure that any	ı	
	The climical mass	ord for Resident B was			residents experiencing		
					gastrointestinal symptoms w	ith a	
	reviewed on 11/17/11 at 3:35 p.m. The				hard and distended abdome	า	
	record indicated				have been assessed and the		
	receiving hospic	e services.			physician notified.A Policy ar		
					Procedure has been develop for Abdominal Assessment.		
	Nurse's Notes si	gned by the hospice nurse					
	indicated the res	ident was seen for routine			licensed nursing staff have b inserviced on the P & P relat		
	hospice visits on	8/18/11, 8/22/11, and			Abdominal Assessment and		
	8/31/11, and Nu	rse's Notes signed by			& P for Physician Notification		
	facility staff indi	icated the resident was			Change of Condition.Nursing Managers will review the 24		
	seen by the podi	atrist on 8/19/11.			shift reports daily to identify a		
					residents experiencing a har		
	The next nursing	g entry was "Nursing			distended abdomen to ensur		
		umentation," dated 9/3/11,			appropriate assessment and		
	_	"Brief Description: N/V			timely physician notification h		
		*			been completed. This audit be completed daily times six		
	_	drawn through] Abdomen d." An instructional			months. Results of the abov		
					audits will be reported to the		
		Form indicated, "Use when			weekly. DON will ensure		
	-	lmissions/readmissions			additional training and/or		
	_	ertinents, abt [antibiotic]			counseling is provided as	_	
	therapy and sym	•			necessary. A summary of th findings will be reported to th		
	illness/behavior	problems, temps			Committee quarterly for a	ic QA	
	[temperatures], etc."				minimum of two quarters. D	ON	
	1 3				and Administrator to monitor		
	Notes on the for	m indicated:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00		(X3) DATE COMPL	
		155614	A. BU B. WI	JILDING NG			11/17/2	
			B. WI		DDRESS, CITY, STA	TE ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			UNTRY CLUB D	*		
LINCOLN	I HILLS OF NEW A	LBANY			_BANY, IN47150			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIATICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFI	icienci)		DATE
	0/3/11 12:40 a m	ı., "Res lg [large]						
		sis & lg pasty BM [bowel						
	•	Il bed strip, T 99.3 ax.						
	_	pointing up] per 3 staff						
		n] HOB [head of bed]						
		up]. Supp [suppository]						
		g & 650 mg Tyl [Tylenol]						
	supp given @ th							
	Supp Biven to the	io ville.						
	9/3/11 2:30 a.m	, "Res lg liq [liquid]						
		this time [symbol for						
	_	gested food. Lg pasty						
	,	again. T 98 ax [axillary]						
		pointing up] again. HOB						
		up]. Cont [continue to						
	monitor]."	13 (
	_							
	9/3/11 6:00 a.m.,	, "Res has had 3						
	[illegible word] l	lg liq emesis [symbol for						
	with] undigested	l food again. T 99.1 Ax.						
	Lg pasty BM ag	gain. Tyl supp 650 again.						
	Will cont to mon	nitor. BS [bowel sounds]						
	+ [positive] all 4	quads and wife notified						
	of res condition.	"						
		[second entry at this						
	time], "Abd hard	d and distended."						
	0/2/11 10:00 a	"Dagidant cent to						
		n., "Resident sent to ospital] to be evaluated.						
	Luame of focal m	ospitatjito od evatuateu.						
	The next entry in	n the Nurse's Notes was						
	_	a.m., and indicated, "Res.						
FORM CMS-2	567(02-99) Previous Version		890C1 ²	Facility I	D: 000321	If continuation sh	neet Par	ge 5 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 11/17/20	ETED	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LINCOLN	I HILLS OF NEW A	LBANY			JNTRY CLUB DRIVE BANY, IN47150		
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	very distended al [name of hospice physician]. He a [name of local he evaluationV/S [blood pressure]. [respirations] 98 [oxygen saturations] 4 hospital History 9/4/11, indicated admitted to the hunderwent sigmon volvulus. During interview p.m., the Directory indicated change Resident B would the hospice, who physician.	[vital signs] 130/78 , 72 [pulse], 20 .7 [temperature], 94%					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155614		LDING		11/17/2011	
		133014	B. WIN			11/11/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE SUNTRY CLUB DRIVE		
LINCOLN	HILLS OF NEW A	LBANY			LBANY, IN47150		
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=D	Each resident must must provide the must provide the must provide the must physical, mental, a in accordance with assessment and p Based on record facility failed to conset of gastroing thoroughly assess condition reporter for 1 of 4 resident change in condition hospitalization in (Resident B) Findings includes The clinical recorreviewed on 11/1 record indicated receiving hospice visits on 8/31/11, and Nurfacility staff indicated the resident by the podiated 9/3/11, ind Description: N/V	st receive and the facility secessary care and services in the highest practicable and psychosocial well-being, in the comprehensive lan of care. review and interview, the ensure a resident with testinal symptoms was sed and change in editimely to the physician attricts reviewed related to ion followed by in a sample of 4. The the resident B was ensured by the hospice nurse dent was seen for routine 8/18/11, 8/22/11, and se's Notes signed by cated the resident was attrict on 8/19/11.	FO	1309	The facility does provide the necessary care and service attain or maintain the highe practicable physical, menta psychosocial well-being, in accordance with the comprehensive assessmen plan of care.Resident B was assessed for gastrointestina symptoms on 9/3/11 at 12:2:30 am, 6:00 am and 10:00 at which time the facility did the MD and resident was set the hospital. Resident read to facility at this time with not further problems noted.Any resident exhibiting gastrointestinal symptoms with a hard and distended abdomen has the potential to be affected. The 24-hour shift report has been reviewed to ensure that any residents experiencing gastrointestinal symptoms whard and distended abdomen has the potential to be affected. The 24-hour shift report has been reviewed to ensure that any residents experiencing gastrointestinal symptoms whard and distended abdomen have been assessed and physician notified. A Nursing Policy and Procedure has been developed for Abdominal Assessment. All licensed not staff have been inserviced on the P&P related to Abdominal Assessment and the P&P Physician Notification of Chemostra.	s to st st st st and st and st al o am, o am notify ent to mitted o st e e n r r r r r r r r r r r r r r r r r	12/13/2011
ı	• •	notation on the form			of Condition.Nursing Manag		

000321

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155614	B. WIN	G		11/17/2	011
	PROVIDER OR SUPPLIER			326 CO	DDRESS, CITY, STATE, ZIP CODE UNTRY CLUB DRIVE _BANY, IN47150		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	·		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE	DATE
	indicated, "Use v	when any incidents,			will review the 24 hour shift		
	admissions/readr	nissions (for 72 hours),			reports daily to identify any residents experiencing		
	pertinents, abt [a	ntibiotic] therapy and			gastrointestinal symptoms v	vith a	
	symptoms, acute	illness/behavior			hard and distended abdome		
	problems, temps	[temperatures], etc."			ensure appropriate assessn	nent	
	Notes on the form	m indicated:			and timely physician notification has been completed This audit will be completed daily times six months. Res		
	9/3/11 12:40 a.m	., "Res lg [large]			of the above audits will be		
	undigested emes	is & lg pasty BM [bowel			reported to the DON weekly	'.	
	movement]. Ful	l bed strip, T 99.3 ax.			DON will ensure additional training and/or counseling is	:	
	Cleaned [arrow p	pointing up] per 3 staff			provided as necessary. A	,	
	[symbol for with] HOB [head of bed]			summary of the findings will		
	[arrow pointing t	up]. Supp [suppository]			reported to the QA Committ quarterly for a minimum of t		
	Phenergan 25 mg	g & 650 mg Tyl [Tylenol]			quarters. DON and Adminis		
	supp given @ thi	is time."			to monitor.		
	brown emesis @ with] some undig BM @ this time Cleaned [arrow p	"Res lg liq [liquid] this time [symbol for gested food. Lg pasty again. T 98 ax [axillary] pointing up] again. HOB up]. Cont [continue to					
	with] undigested Lg pasty BM ag Will cont to mon	g liq emesis [symbol for food again. T 99.1 Ax. ain. Tyl supp 650 again. itor. BS [bowel sounds] quads and wife notified					
	9/3/11 6:00 a.m.	[second entry at this					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		155614	A. BUII B. WIN	LDING G		11/17/2	011
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					UNTRY CLUB DRIVE		
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	time], "Abd hard	i and distended.					
	0/3/11 10:00 a m	., "Resident sent to					
		ospital] to be evaluated.					
		ospital to be evaluated.					
	The next entry ir	the Nurse's Notes was					
		.m., and indicated, "Res.					
		ausea and vomiting] and a					
		bdomen. Call placed to					
	*	e] who called [name of					
	1	dvised to send res. to					
	[name of local he	ospital] for					
	evaluationV/S	[vital signs] 130/78					
	[blood pressure],	, 72 [pulse], 20					
	[respirations] 98	.7 [temperature], 94%					
	[oxygen saturation	on]"					
		ry and Physical, dictated					
	· ·	d the resident was					
		ospital on 9/3/11 for					
	sigmoid colector	ny for volvulus.					
		44/4-144					
		on 11/17/11 at 5:15					
	* '	or of Nursing (DON)					
		nt B had constipation,					
		nusual for Resident B to					
	_	following administration					
		te reviewed the resident's are and indicated the					
		a routine daily stool					
	1	had not received a					
		ion prior to the 9/3/11					
		bowel movement and					
	emesis. The DO	N indicated the wording					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 11/17/2	ETED	
NAME O	F PROVIDER OR SUPPLIEF	· :			DDRESS, CITY, STATE, ZIP CODE		
LINCO	_N HILLS OF NEW A	LBANY			UNTRY CLUB DRIVE LBANY, IN47150		
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	added to the "Nu Documentation" the resident's abo a.m. The DON no policy on what when a resident large pasty bowed indicated changes Resident B would the hospice, who physician. During interview p.m., LPN #15 in any change, she signs. She indict gastrointestinal states assess bowel sout distention. During interview p.m., LPN #3 and would assess a reany change. The assess bowel sout vomiting, and Ll would also meass abdominal girth. Review of the A Directors Association.	after the nurse assessed domen on 9/3/11 at 6:00 indicated the facility had at a nurse should assess developed vomiting and el movements. The DON is in condition for doments assess all vital attends for a resident with a condition for a doment for a factor of the condition for doments in conditi					

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614			(X2) MUI A. BUILI B. WING	DING	OO	(X3) DATE S COMPLI 11/17/20	ETED
	PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE JNTRY CLUB DRIVE BANY, IN47150		
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	signs; abdominal bowel sounds, di rectal evaluation, tenderness, mass rectum (if signs of impaction); prese occult) or undige description of vo inspect for jaund	ag, Physical Data: vital evaluation including stension, and tenderness; including pain or es, or hard stool in of constipation or fecal ence of blood (gross or ested food in vomitus; mitus (color, amount); ice and bruises." s related to Complaint					
F0315 SS=D	assessment, the faresident who enter indwelling cathete the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infect normal bladder fur Based on record facility failed to history of urinary	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless cal condition demonstrates n was necessary; and a continent of bladder receives tent and services to prevent tions and to restore as much nection as possible. review and interview, the tensure a resident with r tract infection was hly when the resident	F03	:15	The facility does ensure that resident who is incontinent of bladder receives appropriate treatment and services to pre urinary tract infections and to	vent	12/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155614 11/17/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE began to experience signs and symptoms restore as much normal bladder function as possible. Resident D of urinary tract infection and elevated was discharged from facility on temperatures. The deficient practice 11/7/11. Any resident with a affected 1 of 4 residents reviewed related history of urinary tract infection who are experiencing signs and to change in condition followed by symptoms of urinary tract hospitalization in a sample of 4. (Resident infection have the potential to be D) affected. The 24-hour shift report has been reviewed and any Findings include: residents experiencing signs or symptoms of urinary tract infection have been The clinical record for Resident D was assessed. Nursing Policy and reviewed on 11/17/11 at 1:40 p.m. The Procedure for Assessment of record indicated the resident's diagnoses Urinary Tract Infection has been revised to include completion of included, but were not limited to, urinary vital signs at the onset of tract infection. The resident received all symptoms; at the time of elevated nutrition and hydration by gastrostomy temperature and/or at the time of tube, and the resident was incontinent. worsening of any symptoms.All licensed nursing staff have been inserviced on revised P & P for Nurse's Notes, dated 11/2/11 at 10:00 Assessment of Urinary Tract a.m., indicated, "Foul smelling urine Infection.Nursing Managers will noted notified supervisor & MD audit the 24-hour shift report daily to ensure that any residents [physician] NO [new order] received exhibiting signs and symptoms of obtain UA C&S [urinalysis with culture urinary tract infection are and sensitivity] next lab day notified appropriately assessed. Audits [name] RP [responsible party] expressed will be completed for a minimum of six months. Results of these understanding." Nurse's Notes indicated a audits will be reported to the DON urine specimen was obtained by straight weekly. DON will ensure catheter at 2:00 a.m., on 11/3/11 and sent additional training and/or to the lab. Nurse's Notes indicated the counseling is provided as necessary. A summary of the results of the urinalysis with culture and findings will be reported to the QA sensitivity was received on 11/5/11 at Committee quarterly for a 2:50 p.m., and the resident's physician minimum of two quarters. DON ordered an antibiotic to which the and Administrator to monitor. organism in the urine was susceptible.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		100014	B. WINC			11/17/2	011
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(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	Documentation for resident's vital sippressure, pulse, resaturation) was not until 11/5/11. A "Nursing Follod dated 11/2/11, in Description: UA foul odor." An inthe form indicated incidents, admiss 72 hours), pertine therapy and sympillness/behavior perform were as followed form were as followed form were as followed form with the form were as followed form were as followed form were as followed form with the form were as followed form were as followed form were as followed form with the form were as followed form were as followed form were as followed form with the form with the form were as followed form were as followed form with the form were as followed form were as followed form with the form with the form were as followed form with the form were as followed form with the form were as followed form with the form with the form were as followed form with the form with the form were as followed form with the form with the form were as followed form with the form were as followed form with the form were as followed form with the form with the form were as followed form were as followed form with the form w	C&S R/T [related to] instructional notation on ed, "Use when any sions/readmissions (for ents, abt [antibiotic] ptoms, acute problems, temps etc." Notations on the lows: "In indicated the was obtained by straight rong odor and very "In m., "Odor continues" "In m., "Odor still noted "In m., "Urine remains eding [symbol for		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMP 11/17/2	LETED	
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COD UNTRY CLUB DRIVE LBANY, IN47150	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	remains." :00 p.m., 11/4/11 at 5:00 p [symbol for with for with] foul ode An untimed nota 11/5/11, indicate temperature was 11/5/11 at 9:00 a temperature was No other docume indicated assessin potential urinary A "Nursing Follo dated 11/5/11, in description: Am g-tube [gastrosto times daily] X [ti temp [temperatur Notations on the temperature on 1 was 97.8, at 10:1 p.m., 99.1 degree at 8:00 p.m., indi appears diaphore [temperature]102 Tylenol given @ pointing up] incr	a.m., "Res. voids out] difficulty [symbol or noted. Will monitor." tion on the form, dated d the resident's 96.9, and a notation on .m. indicated the 97.4 degrees. entation on the form nents related to the tract infection. ow-Up Documentation," dicated, "Brief picillin 500 mg per my tube] TID [three limes] 10 daysMonitor re] qs [every shift]." form indicated the 1/6/11 at 12 midnight 5 a.m., 98.2, and at 2:00 es. A notation on 11/6/11 cated, "Res [resident] tic, temp 2.4, prn [as needed] 8:00 p.m. for [arrow					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155614 11/17/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE closely...." A Nurse's Note for 11/6/11 at 9:30 p.m., indicated, "Rechecked temperature, read 101.7. [name of physician] notified, MD stated to remain on ABT [antibiotic] as long as she is susceptible to it...." A notation on the "Nursing Follow-Up Documentation," dated 11/5/11, "Brief description: Ampicillin 500 mg per g-tube [gastrostomy tube] TID [three times daily] X [times] 10 days....Monitor temp [temperature] qs [every shift]," indicated for 11/7/11 at 12 midnight, "T 99.1 oral gave Tyl prn as ordered. MD aware of temp & change in condition on ABT R/T UTI." Other notations indicated, 11/7/11 at 5:00 a.m., "T 101.9 oral. Cont. [continue] to monitor," 11/7/11 at 5:15 a.m., R/T T 101.9 oral. Adm [administered] Tylenol at this time & cont [symbol for with] wet cool wash cloths to forehead & armpits," 11/7/11 at 8:00 a.m., "T 97.3 will continue to monitor, "11/7/11 at 8:30 a.m., "[name of physician] here & advised him resident's temp @ 5:15 a.m. 101.9. [Name of physician] states continue Ampicillin temp likely R/T UTI." Documentation failed to indicate the resident was assessed on 11/7/11 between midnight and 5:00 a.m., between 5:00 a.m.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

890C11

Facility ID:

000321

If continuation sheet

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI — 11/17/2	ETED		
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	and 8:00 a.m., and 11:30 a.m.	nd between 8:00 a.m. and					
	indicated, "BS [I [maximum] slidid [Assistant Direct notified will reconstilled will reconstill will be a subject to the su	r 11/7/11 at 11:30 a.m., blood sugar] 435 max ling scale given. ADON tor of Nursing] and MD block in 30 minutes." r 11/7/11 at 12:00 p.m., cool and clamy [sic] B/P 103.1, R 32, O2 sats long 89% on RA [room d NO [new order] 1. supp [suppository] 650 four hours] [arrow ler 2. Duoneb q 4 h prn [as la [shortness of air] Check tx [treatment] O2 at @ 2 minute] to maintain at or obtain CXR [chest					
	indicated, "AC [check] 461 call p	r 11/7/11 at 12:15 p.m., check mark] [blood sugar blaced to MD left ng return phone call."					
	indicated, "[nam call. N.O. D/C [Duoneb q 4 [syn [antibiotic] 1 gm	r 11/7/11 at 1:55 p.m., e of physician] returned discontinue] Ampicillin, abol for hours], Rocephin a IM [intramuscular bol for no] N.O. R/T					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614		LDING	NSTRUCTION 00	(X3) DATE COMPL 11/17/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
					UNTRY CLUB DRIVE		
LINCOLN HILLS OF NEW ALBANY				<u> </u>	_BANY, IN47150		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)		N SHOULD BE COMPLETION HE APPROPRIATE	
TAG							
	[arrow pointing]	up] blood sugars. Call					
		er & we were told she is					
	on her way to fac	cility."					
		r 11/7/11 at 2:00 p.m.,					
		[daughter] arrived at					
		d res be sent to [name of					
		R [emergency room] B/P notified ADON, DON					
	[Director of Nursing], MD NO may send to [name of local hospital] ER for evaluation & tx."						
	Hospital History	and Physical, dictated					
	11/8/11, indicate	ed Resident D was					
		ospital on 11/7/11 with					
		nission: Sepsis with					
	dehydration and	-					
	hypotension, dia	_					
	Clostridium difficile and urinary tract infection."						
	miccuon.						
	During interview	v on 11/17/11 at 5:15					
	_	ndicated she had been to					
	* '	m about 12:20 p.m.,on					
	11/7/11, and also	at the time the resident					
		to the hospital at 2:00					
	^	indicated the resident had					
	_	oonsive between the					
		second visits. She					
		rse obtained a full set of					
	_	the resident's skin					
		clammy, which was a					
	change in condit	ion. The DON indicated					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155614	B. WIN	G		11/17/2	011
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					UNTRY CLUB DRIVE		
LINCOLI	N HILLS OF NEW A	ALBANY		NEW AL	LBANY, IN47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!		DATE
		essary previously, because					
		not had a change of					
		DON indicated the facility the resident to the					
		n even if the resident's					
	_	t been present to make the					
	request.						
	During interview	v on 11/17/11 at 6:30					
		ndicated when a resident					
		urinary tract infection or					
	-	for urinary tract infection,					
		et a nurse to check only					
	_	nperature. She indicated					
		rperature. She indicated					
		•					
		vital signs or complete					
	_	essments "unless					
	something else s	starts to occur.					
	Review of Lippincott's Pocket Manual of Nursing Practice, second edition, indicated for "Urinary Tract Infection in Adults, Lower," "Assessment: 1. Dysuria, frequency, urganey, poeturio: 2						
	frequency, urgency, nocturia; 2.						
	Suprapubic pain and discomfort; 3. Hematuria; 4. May be asympomatic;						
	Gerontologic Alert: The only sign of UTI						
	in the elderly may be mental status						
	change."						
	onange.						
	Review of the A	merican Medical					
	Directors Associ						
		fore You Call Data					
		em, 2010" indicated to					
	1 Jones Hon Dyste	in, 2010 maioatoa to					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	(X2) MU A. BUIL B. WING	DING	00	(X3) DATE S COMPL 11/17/20	ETED
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	following assessing Physical Data: Volume (continuous, interpretation of alternating few chills, fatigue, or of inflammation or increased difference - increased in	ments for "Fever, Vital signs; Fever patterns rmittent, etc.); Any signs rer and rigors (shaking, pain), diaphoresis; Signs or infection at specific lungs, skin, etc.); Any rec, lung, or abdominal re, muscle aches, clinical on (postural pulse rase from lying down to g or 30 beats per minute rdia, rapid weight loss, st, new onset or increased , loss of appetite.		IAU	Jan Clark City		DATE
F0514 SS=D	each resident in according professional stand complete; accurate accessible; and sy The clinical recordinformation to identhe resident's asseand services provipreadmission screes tate; and progress Based on recording facility failed to expect the second was accurate.	naintain clinical records on accordance with accepted ards and practices that are ely documented; readily estematically organized. must contain sufficient are ely the resident; a record of essments; the plan of care ded; the results of any ening conducted by the ess notes. review and interview, the ensure the resident's atterelated to tube 4 residents whose	F0.	514	The facility does maintain clir records on each resident in accordance with accepted professional standards and practices that are complete;	nical	12/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/17/2011		
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	records were revidocumentation in (Resident D) Findings included The clinical recordinct reviewed on 11/record included for November 20/Record indicated tube feeding of 0/by pump at 50 cc Flow Record als received 120 cc medications at 6 p.m., and 7:00 p the Enteral Flow the tube feeding administered on nursing shifts (6 2:00 p.m. to 10:00 p.m., LPN administered Re and water flushed and second shifts not documented Enteral Flow Re	riewed for accuracy of in a sample of 4. 2: 2: 2: 2: 2: 2: 2: 2: 2: 2			accurately documented; reaccessible; and systematics organized. Resident D discrifrom the facility on 11/7/11. residents receiving enteral feedings have the potential affected. The enteral flow records for those residents receiving enteral feedings have the potential affected. The enteral flow records for those residents receiving enteral feedings have received for completion. LPN #11 has be counseled regarding accurate completion of enteral flow records. All licensed nursing have been inserviced regar accurate completion of enteral flow records. Nursing Managuill audit enteral flow record weekly times four weeks, make one month and then quarterly times one quarter. Results of these audill be reported to the DON weekly. DON will ensure the additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the Committee quarterly for a minimum of two quarters. Do and Administrator to monitors.	ally arged All to be ave en ate staff ding eral gers is onthly dits at he ADN	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155614		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/17/2011
		326 CC	DUNTRY CLUB DRIVE	
SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
			CROSS-REPERENCED TO THE APPROPRIADEFICIENCY)	NIE
	OF CORRECTION ROVIDER OR SUPPLIE HILLS OF NEW A SUMMARY S (EACH DEFICIEN REGULATORY OF 3.1-50(a)(1)	IDENTIFICATION NUMBER: 155614 ROVIDER OR SUPPLIER HILLS OF NEW ALBANY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3.1-50(a)(1)	TO F CORRECTION IDENTIFICATION NUMBER: 155614 ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET 326 CC NEW A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 3.1-50(a)(1)	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE HILLS OF NEW ALBANY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3.1-50(a)(1) DO DETICIENCY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)